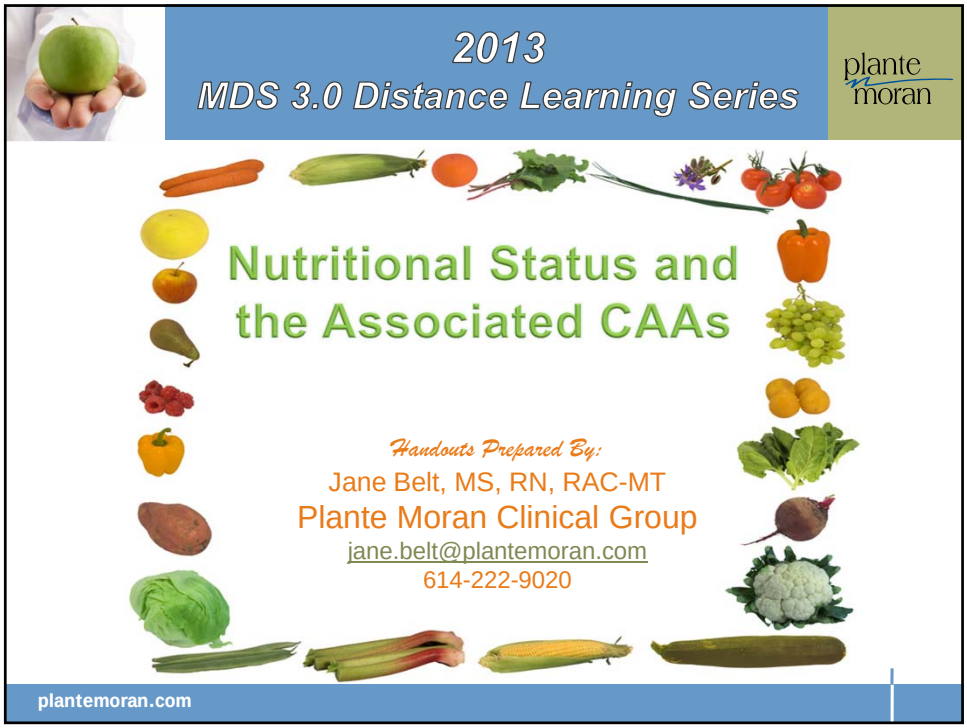
2013
MDS 3.0 Distance Learning Series
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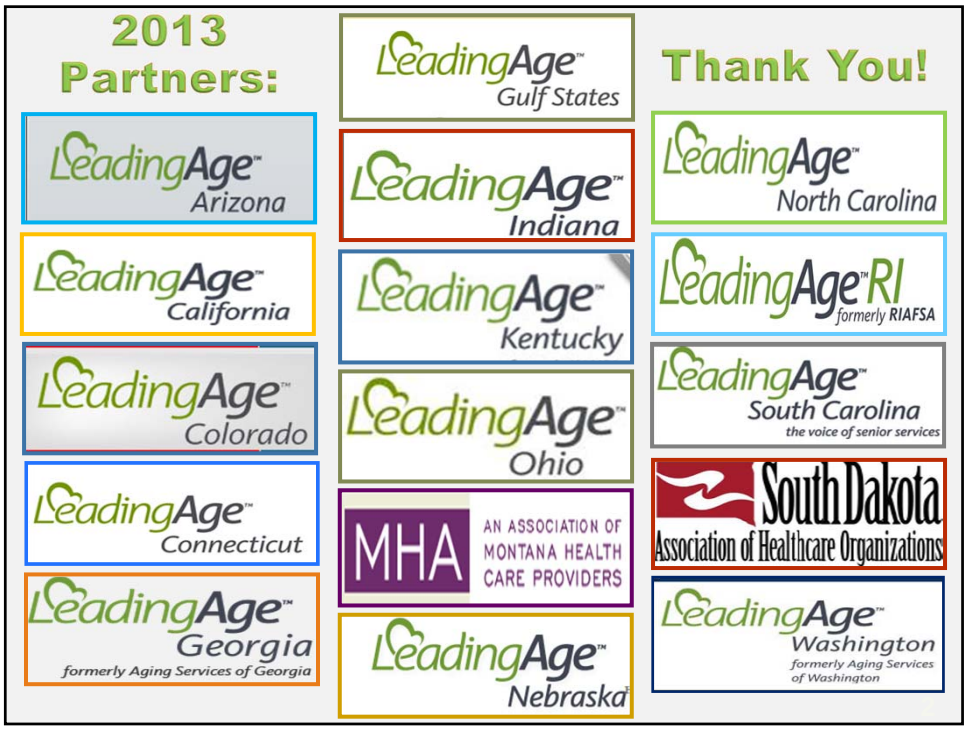
Nutritional Status and the Associated CAAs
Handouts Prepared By:
Jane Belt, MS, RN, RAC-MT
Plante Moran Clinical Group
jane.belt@plantemoran.com
614-222-9020
plantemoran.com


2013 Partners:
LeadingAge Arizona
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LeadingAge Colorado
LeadingAge Connecticut
LeadingAge Georgia
formerly Aging Services of Georgia
LeadingAge Gulf States
LeadingAge Indiana
LeadingAge Kentucky
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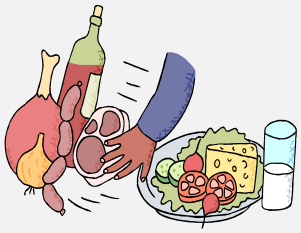
formerly RIAFSA
LeadingAge South Carolina
the voice of senior services
South Dakota
Association of Healthcare Organizations
LeadingAge Washington
formerly Aging Services of Washington

Objectives

1. Review of the assessment types and when to use them.
2. Delineation of the items in Sections K
3. Use of the Care Area Assessments for Dietary
4. Questions and Answers



The Resident Assessment Instrument

Omnibus Reconciliation Act (OBRA)'87 - the nursing home reform law - provided an opportunity to ensure good clinical practice by creating a regulatory framework that recognized the importance of comprehensive assessments as the foundation for planning and care delivery to nursing home residents

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Certification Requirements F272

- The intent of the assessment is to provide the facility with ongoing assessment information to develop a care plan, to provide appropriate care and services for each resident, and to modify the care plan and care/services based on the resident's status

"Right" Forms and Manual

- All Item Sets must indicate the correct version (1.10.4) and date (04/01/2012):

MDS 3.0 Nursing Home Comprehensive (NC) Version 1.10.4 Effective 04/01/2012

- Long-Term Care Facility Resident Assessment Instrument User's Manual – May 2013 – v1.10

https://www.cms.gov/NursingHomeQualityInits/45_NHQIMDS30TrainingMaterials.asp#TopOfPage

- More updates expected in late summer for 10/01/13

RAI Process

Purpose

- To promote the highest practicable level of functioning for a resident through an assessment of triggered care areas
- To understand the causes and contributing factors of identified problems
- Development of resident-specific care plan based on identified problems, needs, strengths

The Overall RAI Framework

Minimum Data Set (MDS) +

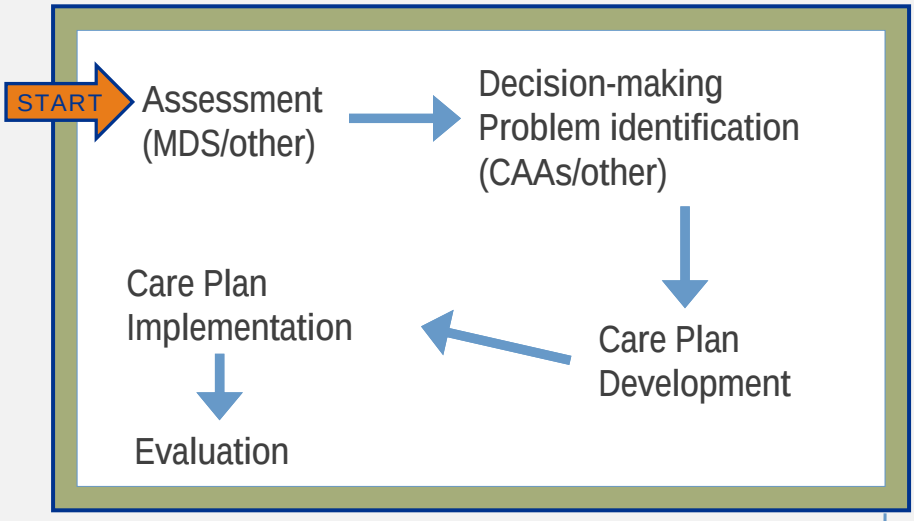
Care Area Assessments (CAAs) +

Utilization Guidelines +

Care plan =

Comprehensive Assessment

RAI Philosophy – Problem Solving



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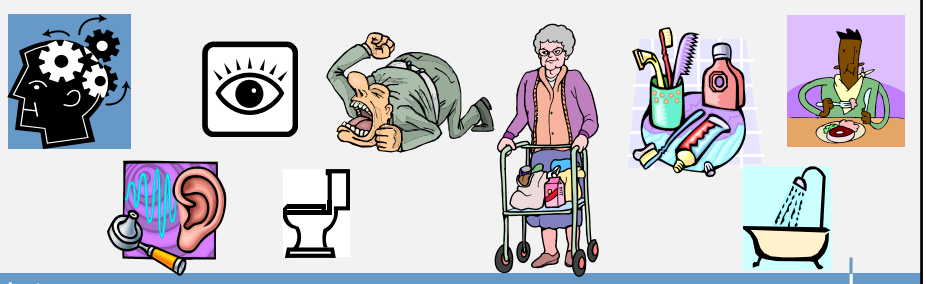
RAI Process Components

Minimum Data Set (MDS)

- Core set of standardized screening, clinical, physical, functional, and psychosocial status items that form the **foundation** of the comprehensive, **functional status** assessment



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RAI Process Components

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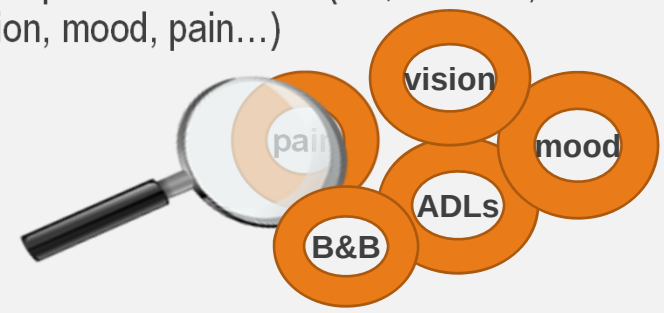
Care Area Triggers (CATs)

- MDS answer options that provide clues to possible problems, needs, strengths in any of the 20 specific care areas (i.e., delirium, nutrition, mood, pain…)



RAI Process Components

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Care Area Assessments (CAAs)

- MDS is not a complete assessment – it is a screening tool
- Further assessment of entire triggered care area is required, using sound clinical problem-solving and decision-making skills, to be able to draw conclusions about problems, needs and strengths

RAI Process Components

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Utilization Guidelines

- Provide instructions for when and how to use RAI
- Include instructions for completion of RAI as well as structure frameworks for synthesizing MDS and other clinical information
- https://www.cms.gov/manuals/downloads/som107app_pp_guidelines_ltcf.pdf

CMS.gov
Centers for Medicare & Medicaid Services

RAI Process Components

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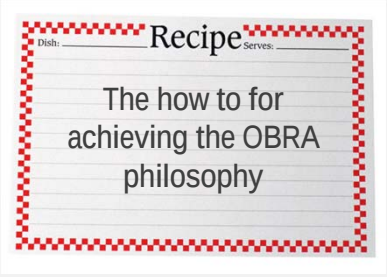
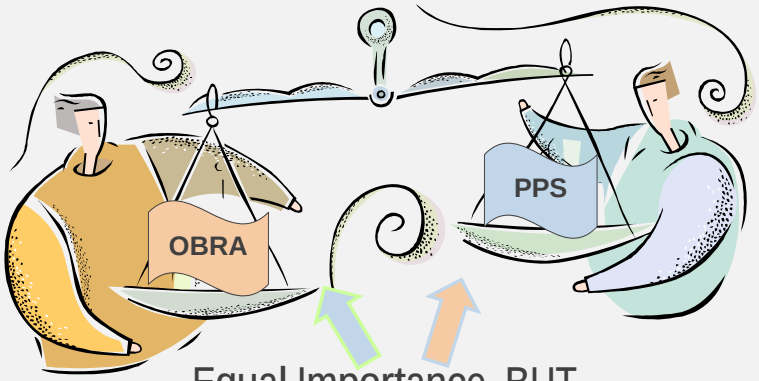
Six General Care Planning Areas

1. Functional status
2. Rehabilitation/restorative nursing
3. Health maintenance
4. Discharge potential
5. Medications
6. Daily care needs



The Balancing Act



Equal Importance, BUT…

Different

Regulations | Time frames | Situations | Payment systems | Grouper criterion | Optimization strategies

OBRA Schedule

Comprehensive (MDS/CAAs/Care Plan)	Non-Comprehensive (MDS)
Admission – 14 days	Quarterly – 92 days ARD to ARD
Annual – 366 days ARD to ARD	Significant Correction to Prior Quarterly (SCQA) – 14 days
Significant Change in Status (SCSA) – 14 days	Entry record – entry + 7 days
Significant Correction to Prior Comprehensive (SCPA) – 14 d	Discharge (return anticipated or return not anticipated) – 14 days
	Death in facility – DOD + 7 days

MDS 3.0 Assessment Types

Federal OBRA Reason for Assessment Nursing Home Comprehensive (NC) Item Set	A0310A Code
• Admission assessment (required by day 14)	01
• Annual assessment	03
• Significant change in status assessment	04
• Significant correction to prior comprehensive assessment	05

Enter Code

Comprehensive Assessments

- Admission (A0310A = 01)
  - Day begins at 12:00 AM
  - Ends at 11:59 PM

  } No matter time admitted = Day 1 of admission
  - ARD = no later than 14th day of admission
  - MDS completion date (Z0500B) and CAAs completion date (V0200B2) = no later than 14th day
  - Care plan completion date (V0200C2) = CAAs completion date + 7 days
  - Submission = care plan completion date + 14 days

Comprehensive Assessments

- Annual (A0310A = 03)
  - ARD = no later than
    - ARD of previous comprehensive + 366 days ***AND***
    - ARD of previous quarterly + 92 days
  - MDS completion date (Z0500B) and CAAs completion date (V0200B2) = ARD + 14 days
  - Care plan completion date (V0200C2) = CAAs completion + 7 days
  - Submission = care plan completion date + 14 days

Comprehensive Assessments

- Significant change in status (SCSA)(A0310A = 04):
  - ARD = no later than 14th day after determination
  - MDS completion date (Z0500B) and CAAs completion date (V0200B2) = no later than 14th day after determination (ARD + 14 days)
  - Care plan completion date = CAAs completion date + 7 days
  - Submission = care plan completion + 14 days

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Scheduled PPS Schedule

Defined days within which the ARD must be set

MDS	Reason A0310B	ARD Days	Grace Days	Payment Days
5-day	01	1 – 5	6 – 8	1 thru 14
14-day	02	13 – 14	15 – 18	15 thru 30
30-day	03	27 – 29	30 – 33	31 thru 60
60-day	04	57 – 59	60 – 63	61 thru 90
90-day	05	87 – 89	90 – 93	91 thru 100

Change of Therapy (COT) Assessment OPTION (page 2-51)

- COT has a rolling seven (7) day observation once a therapy RUG has been established and is ***required*** when the RUG category for rehab or rehab with extensive services will change for billing purposes – ***EXCEPT……..***
- If day seven (7) of the COT observation period falls within the ARD window of a **scheduled** PPS assessment, the SNF *may choose* to complete the PPS assessment ***ALONE*** by setting the ARD of the scheduled PPS MDS for an allowable day that is ***on or prior to*** Day 7 of the rolling window – the COT window is reset

Change of Therapy (COT) Assessment Clarification (page 2-51)

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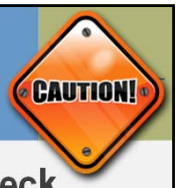
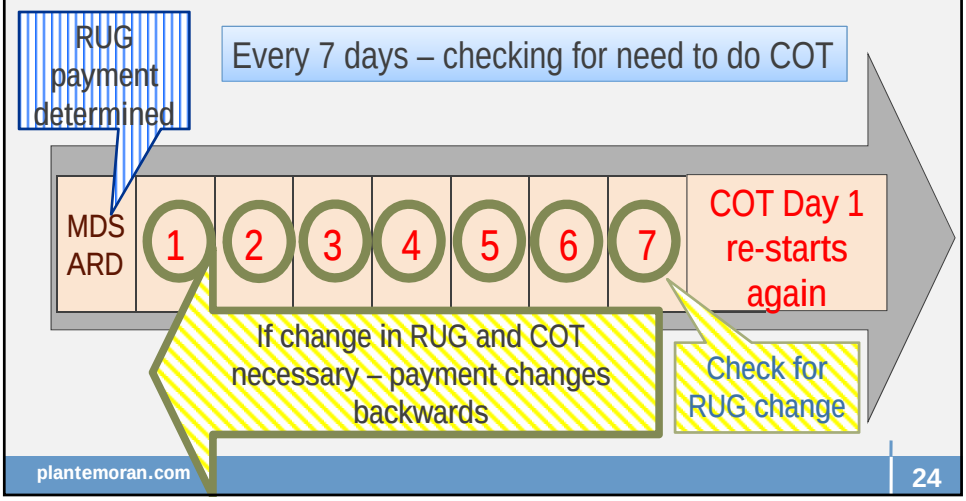
- In cases where a resident is ***discharged*** from the SNF ***on or prior to*** Day 7 of the COT observation period, **then no COT OMRA is required**
- RAI Manual goes on to say: "If a facility chooses to complete the COT OMRA in this situation they may combine the COT OMRA with the discharge assessment"

THINK ABOUT THAT ----- be careful!!!! COT pays backwards!!!!

A Quick Word of Caution



- Change of Therapy Assessments (COT) Check



Possible COT Signals

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- Considerations – could trigger a COT:
  - Missed treatment sessions (resident illness, scheduling conflict, family visit, outing, refusals, withheld treatments, holidays with missed sessions, therapist illness)
  - Partial treatment sessions
  - Changes in rehab intensity and/or disciplines
  - Discontinuation of or starting therapies
  - Inconsistent delivery and poor communication

Assessment Reference Date (ARD)

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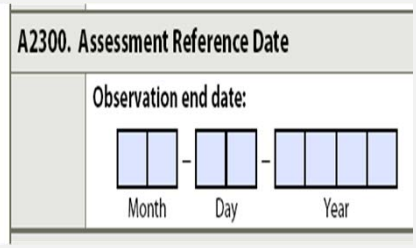
- Timing the same (366 days for the annual and 92 days for the quarterly)
- Timing for next assessment based on the ARD
- Anything that happens after the ARD will not be reflected on the MDS



- The facility is required to set the ARD on the MDS form itself or in the facility software within the appropriate timeframe of the assessment being completed

Instructions for Coding "8" in ADLs

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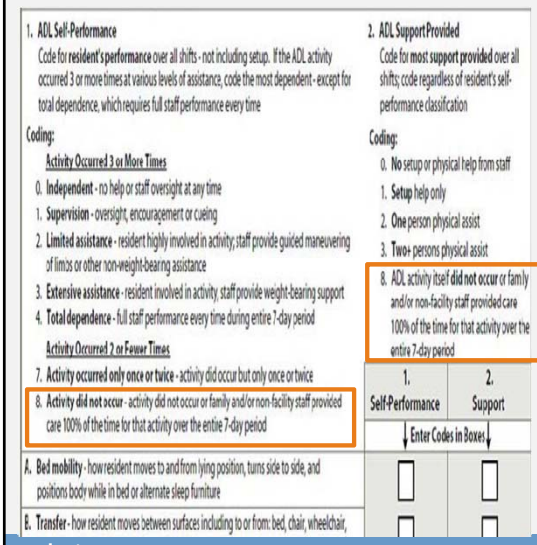

1. ADL Self-Performance
Code for **resident's performance** over all shifts - not including setup. If the ADL activity occurred 3 or more times at various levels of assistance, code the most dependent - except for total dependence, which requires full staff performance every time

Coding:

Activity Occurred 3 or More Times

0. **Independent** - no help or staff oversight at any time
1. **Supervision** - oversight, encouragement or cueing
2. **Limited assistance** - resident highly involved in activity; staff provide guided maneuvering of limbs or other non-weight-bearing assistance
3. **Extensive assistance** - resident involved in activity; staff provide weight-bearing support
4. **Total dependence** - full staff performance every time during entire 7-day period

Activity Occurred 2 or Fewer Times

7. **Activity occurred only once or twice** - activity did occur but only once or twice
8. **Activity did not occur** - activity did not occur or family and/or non-facility staff provided care 100% of the time for that activity over the entire 7-day period

2. ADL Support Provided
Code for **most support provided** over all shifts; code regardless of resident's self-performance classification

Coding:

0. **No** setup or physical help from staff
1. **Setup** help only
2. **One** person physical assist
3. **Two+** persons physical assist
8. ADL activity itself **did not occur** or family and/or non-facility staff provided care 100% of the time for that activity over the entire 7-day period

	1. Self-Performance	2. Support
	Enter Codes in Boxes	
A. **Bed mobility** - how resident moves to and from lying position, turns side to side, and positions body while in bed or alternate sleep furniture		
B. **Transfer** - how resident moves between surfaces including to or from: bed, chair, wheelchair,		

Code 8, ADL activity itself did not occur during the entire period: if the activity did not occur or family and/or non-facility staff provided care 100% of the time for that activity over the entire 7-day period.

Know the ADL Definitions of Self-Performance

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0	Independent
1	Supervision
2	Limited Assistance
3	Extensive Assistance
4	Total Dependence
7	Activity Occurred Only Once or Twice
8	Activity Did Not Occur

Tip: Staff's hand on top

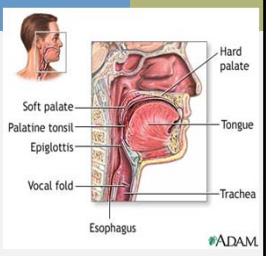
Tip: Staff's hand underneath - hand, finger, arm, leg, hip, foot of resident

Section K – Swallowing/Nutritional Status

- Intent
  - Assess the many conditions that could affect resident's ability to maintain adequate nutrition and hydration
  - Items cover:
    - Swallowing disorders
    - Height and weight
    - Weight change
    - Nutritional approaches

K0100 – Assessment

- K0100 Swallowing Disorder
  - Ask resident about any difficulty swallowing during the look-back period
  - Ask about each symptom
  - Observe resident to identify any symptoms
    - During meals
    - At times resident is eating, drinking, or swallowing
  - Interview staff members across all shifts
  - Review medical record – nursing, physician, dietitian, ST notes, dental history or problems



Section K0100 – Swallowing

K0100. Swallowing Disorder Signs and symptoms of possible swallowing disorder ↓ Check all that apply	
☐	A. Loss of liquids/solids from mouth when eating or drinking
☐	B. Holding food in mouth/cheeks or residual food in mouth after meals
☐	C. Coughing or choking during meals or when swallowing medications
☐	D. Complaints of difficulty or pain with swallowing
☐	Z. None of the above

Code a symptom even if it only occurred once during the 7-day look back

- Do NOT code a swallowing problem if interventions have been successful in treating the problem – the intervention is successful

Section K0200A – Height

- Base height on the most recent height since the most recent admission/entry or reentry. Measure and record height in inches
- Measure height consistently over time in accordance with the facility policy and procedure, which should reflect current standards of practice (shoes off, etc.)
- For future assessments, check medical record. If the last height recorded was > 1 year ago, measure and record the resident's height again
- Record height to the nearest whole inch
- Use mathematical rounding

Section K0200B – Weight

- Base weight on the most recent measure in the last 30 days
- Measure weight consistently over time using facility policy and procedure, reflecting current standards of practice (shoes off, etc.)
- For future assessments, check the medical record and enter the weight taken within 30 days of the ARD of this assessment
- If last recorded weight was taken > than 30 days prior to the ARD of this assessment or previous weight is not available, weigh the resident again
- If the resident's weight was taken more than once during the preceding month, record the most recent weight
- Use mathematical rounding and use this number before completing the weight loss or weight gain calculations

Section K – Swallowing and Nutritional Status

- Weight Loss (K0300): From the medical record, compare the resident's weight in the current observation period to his or her weight in the observation period 30 days ago. (p. K-5)
  - From the medical record, compare the resident's weight in the *current observation period (deleted, 7-day look back)* to his or her weight in the observation period 30 days ago
  - If the current weight is less than the weight in the observation period 30 days ago, calculate the percentage of weight loss

Weight Loss (K0300) - continued:

- From the medical record, compare the resident's weight in the *current observation (deleted, 7-day look back) period* to his or her weight in the observation period 180 days ago
- If the current weight is less than the weight in the observation period 180 days ago, calculate the percentage of weight loss

- "Current observation period" defined in K0100, Weight =
  - "Base weight on the most recent measure in the last 30 days. If the last recorded weight was taken more than 30 days prior to the ARD of this assessment or previous weight is not available, weigh the resident again." (p. K-3)

Calculate Percentages of Weight Loss

- Use mathematical rounding before calculation
- Multiply previous weight by 0.95 to determine resident weight after 5% weight loss
  - Example: 160 pounds X 0.95 = 152 pounds. A resident whose weight drops from 160 to 152 pounds or less has experienced 5% or more weight loss
- Multiply previous weight by 0.90 to determine resident weight after 10% weight loss
  - Example: 160 pounds X 0.90 = 144 pounds. A resident whose weight drops from 160 to 144 pounds or less has experienced 10% or more weight loss

Definitions

- Physician-Prescribed Weight Loss Regimen: a weight reduction plan ordered by the resident's physician with the care plan goal of weight reduction. May employ a calorie-restricted diet or other weight loss diets and exercise. Also includes planned diuresis. It is important that weight loss is intentional
- Body Mass Index (BMI): a number calculated from a person's weight and height – used as a screening tool to identify possible weight problems for adults

Coding

Code weight loss based on whether it was planned/managed or unplanned/unmanaged

K0300. Weight Loss	
Enter Code ☐	**Loss of 5% or more in the last month or loss of 10% or more in last 6 months** 0. **No** or unknown 1. **Yes, on** physician-prescribed weight-loss regimen 2. **Yes, not on** physician-prescribed weight-loss regimen

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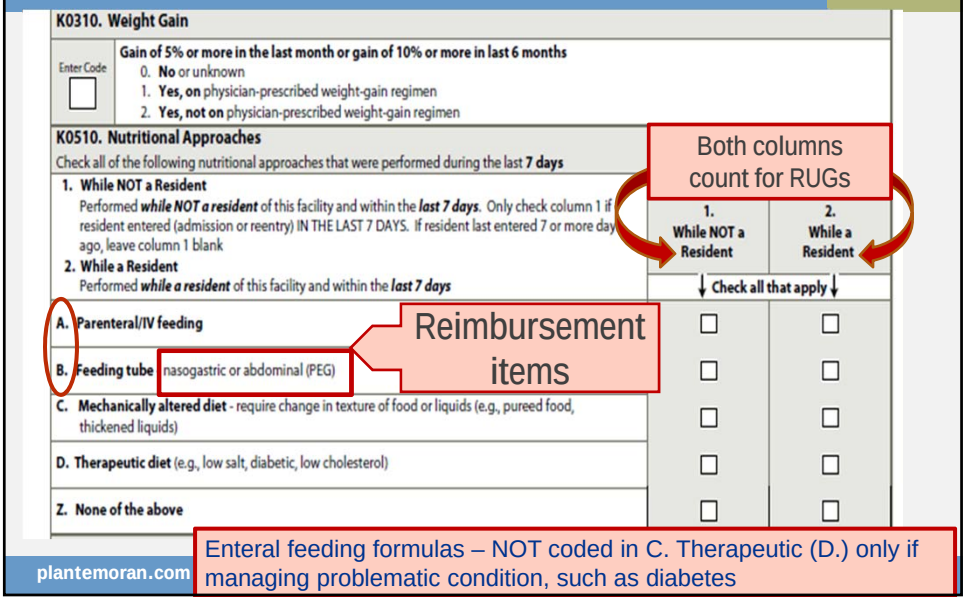
Section K – Swallowing and Nutritional Status

- K0310 – Weight Gain
  - Item compares the resident's weight in the current observation period with his or her weight at two snapshots in time:
    - At a point closest to 30-days preceding the current weight
    - At a point closest to 180-days preceding the current weight
- Physician-Prescribed Weight-Gain Regimen: the weight gain was planned and pursuant to a physician's order

Section K – K0510


K0310. Weight Gain
Enter Code
Gain of 5% or more in the last month or gain of 10% or more in last 6 months
0. No or unknown
1. Yes, on physician-prescribed weight-gain regimen
2. Yes, not on physician-prescribed weight-gain regimen
K0510. Nutritional Approaches
Check all of the following nutritional approaches that were performed during the last 7 days
1. While NOT a Resident
Performed while NOT a resident of this facility and within the last 7 days. Only check column 1 if
resident entered (admission or reentry) IN THE LAST 7 DAYS. If resident last entered 7 or more day
ago, leave column 1 blank
2. While a Resident
Performed while a resident of this facility and within the last 7 days
Both columns count for RUGs
1. While NOT a Resident
2. While a Resident
Check all that apply
A. Parenteral/IV feeding
B. Feeding tube
nasogastric or abdominal (PEG)
Reimbursement items
C. Mechanically altered diet - require change in texture of food or liquids (e.g., pureed food, thickened liquids)
D. Therapeutic diet (e.g., low salt, diabetic, low cholesterol)
Z. None of the above
Enteral feeding formulas – NOT coded in C. Therapeutic (D.) only if managing problematic condition, such as diabetes

K0510 Nutritional Approaches Coding

- Review the medical record to determine if any of the listed nutritional approaches were received performed during the 7-day look back period.
- Coding Instructions for Column 1
  - Check all nutritional approaches performed prior to admission/entry or reentry to the facility and within the 7-day day look-back period. Leave Column 1 blank if the resident was admitted/entered or reentered the facility more than 7 days ago.

K0510 Nutritional Approaches Coding

- Coding Instructions for Column 2
  - Check all nutritional approaches performed after admission/entry or reentry to the facility and within the 7 day look-back period
- K0510A. parenteral/IV feedings
- K05010B. feeding tube – nasogastric or abdominal (PEG)
- K0501C. mechanically altered diet – requires change in texture of food or liquids (e.g., pureed food, thickened liquids)
- K05010D. therapeutic diet (e.g., low salt, diabetic, low cholesterol)
- K05010Z. none of the above

K0510A – Parenteral/IV Feeding

- Code when supporting documentation reflects need for additional fluids addressing nutrition or hydration need:
  - IV fluids or hyperalimentation, including TPN administered continuously or intermittently
  - IV fluids running at Keep Vein Open (KVO)
  - IV fluids contained in IV piggybacks
  - Hypodermoclysis and subcutaneous ports in hydration therapy
  - IV fluids can be coded if needed to prevent dehydration if the additional fluid intake is specifically needed for nutrition and hydration and documented as such

K0510A – Parenteral/IV Feeding

- Do NOT code the following in K0510A:
  - IV medications
  - IV fluids administered as a routine part of an operative or diagnostic procedure or recovery room stay
  - IV fluids administered solely as flushes
  - IV fluids administered in conjunction with chemotherapy or dialysis

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Definitions

- K0510A. Parenteral/IV Feeding = introduction of a nutritive substance into the body by means other than the intestinal tract (e.g., subcutaneous, intravenous)
- K0510B. Feeding tube = presence of any type of tube that can deliver food/nutritional substances/fluids/medications directly into the gastrointestinal system. Examples include, but are not limited to: nasogastric tubes, gastrostomy tubes, jejunostomy tubes, percutaneous endoscopic gastrotomy (PEG) tubes

Definitions

- K0510C. Mechanically altered = a diet specifically prepared to alter the texture or consistency of food to facilitate oral intake. Examples include: soft solids, pureed foods, ground meat, and thickened liquids
- K0510D. Therapeutic diet = a diet intervention ordered by a health care practitioner as part of the treatment for a disease or clinical condition manifesting an altered nutritional status, to eliminate, decrease, or increase certain substances in the diet (e.g., sodium, potassium) (ADA 2011)

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Coding Tips

- Therapeutic diets are not defined by the content of what is provided or when it is served, but WHY the diet is required
- A nutritional supplement (house supplement or packaged) given as part of the treatment for a disease or clinical condition manifesting in altered nutrition status, does not constitute a therapeutic diet, but may be PART of a therapeutic diet. Supplements only coded when administered as a part of a therapeutic diet to manage problematic health conditions

K0700 Percent Intake by Artificial Route

K0700. Percent Intake by Artificial Route - Complete K0700 only if Column 1 and/or Column 2 are checked for K0510A and/or K0510B	
Enter Code ☐	A. Proportion of total calories the resident received through parenteral or tube feeding 1. 25% or less 2. 26-50% 3. 51% or more
Enter Code ☐	B. Average fluid intake per day by IV or tube feeding 1. 500 cc/day or less 2. 501 cc/day or more

- Only coded if column 1 and/or column 2 are checked for K0510A and/or K0510B

K0700A Proportion of Total Calories Received through Parenteral or Tube Feedings in Last 7 Days

- Review records to determine intake
- If resident took no food or fluids by mouth or just sips of fluid, stop here and code “3”, 51% or more
- If oral intake more than this, total oral intake calories and total tube intake calories. Divide the tube calories by the total calories X 100 = % of calories by tube feeding

K0700B Average Fluid Intake per Day by IV or Tube Feeding in Last 7 Days

- Review intake records from the last 7 days
- Add up total amount of fluids received each day by IV and/or tube feeding only
- Divide this total fluid intake by 7
- Divide by 7 even if the resident did not receive IV fluids and/or tube feeding on each of the 7 days

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M1200 Reminders

- Review the medical record; speak with direct care staff
- Observe the resident

M1200. Skin and Ulcer Treatments	
↓ Check all that apply	
☐	A. Pressure reducing device for chair
☐	B. Pressure reducing device for bed
☐	C. Turning/repositioning program
☐	D. Nutrition or hydration intervention to manage skin problems
☐	E. Pressure ulcer care
☐	F. Surgical wound care
☐	G. Application of nonsurgical dressings (with or without topical medications) other than to feet
☐	H. Applications of ointments/medications other than to feet
☐	I. Application of dressings to feet (with or without topical medications)
☐	Z. None of the above were provided

Based on an individualized nutritional assessment

M1200D.

- M1200D. Nutrition or Hydration intervention to Manage Skin Problems
  - Dietary measures received by the resident for the purpose of preventing or treating specific skin conditions, e.g., wheat-free diet to prevent allergic dermatitis, high calorie diet with added supplementation to prevent skin breakdown, high-protein supplementation for wound healing

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More M1200D.

- M1200D Nutrition or Hydration Interventions to Manage Skin Problems
  - Provides additional instruction and enhanced examples. Goal to illustrate that the use of vitamins and mineral supplements are utilized only if nutritional deficiencies have been confirmed or suspected through thorough assessment – not automatically implemented
  - Additional supplementation is not automatically required for pressure ulcer management. Any interventions should be specifically tailored to the resident's needs, condition, and prognosis

RAI Process Components

CAA Summary (Section V)

- Provides location for documentation of triggered care areas and decisions whether to proceed to care planning or not

V0200A – CAA Results

A. CAA Results			
Care Area	A. Care Area Triggered	B. Care Planning Decision	Location and Date of CAA documentation
	↓ Check all that apply ↓		
01. Delirium	☐	☐	
02. Cognitive Loss/Dementia	☐	☐	
03. Visual Function	☐	☐	
04. Communication	☐	☐	
05. ADL Functional/Rehabilitation Potential	☐	☐	
06. Urinary Incontinence and Indwelling Catheter	☐	☐	
07. Psychosocial Well-Being	☐	☐	
08. Mood State	☐	☐	
09. Behavioral Symptoms	☐	☐	
10. Activities	☐	☐	
11. Falls	☐	☐	
12. Nutritional Status	☐	☐	
13. Feeding Tube	☐	☐	
14. Dehydration/Fluid Maintenance	☐	☐	
15. Dental Care	☐	☐	
16. Pressure Ulcer	☐	☐	
17. Psychotropic Drug Use	☐	☐	
18. Physical Restraints	☐	☐	
19. Pain	☐	☐	
20. Return to Community Referral	☐	☐	

Use "Location and Date of CAA documentation" column to note where CAA information and decision-making documentation can be found in the medical record

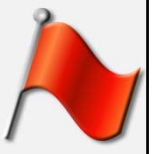
In the column "Care Planning Decision" mark whether the triggered care area is addressed in the care plan

What are the CAAs?

- *CAA process framework*. Guides the review of triggered areas and clarification of a resident's functional status and related causes of impairments. Basis for additional assessment of **potential issues**, including related **risk factors**. Assessment of **causes** and **contributing factors** gives the IDT additional information to help develop a comprehensive plan of care
- After completing CAA evaluation and analysis, a **clinical decision is made** about whether the identified problem is, in fact a problem or relevant issue

Care Area Assessment Triggers

- The trigger (CAT) is an MDS response indicating clinical factors exist that may or may not represent a condition that should be care planned
- When a resident's status on a particular MDS item matches one of the CATs → the related care area is ***triggered*** for further assessment



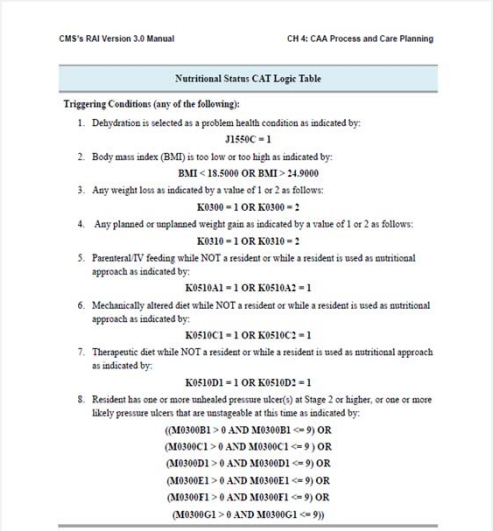
Care Area Assessment Triggers

- Triggers flag conditions that warrant further investigation: a) single response, b) combination of more than one response; c) comparison of resident's current status and prior assessment
- The trigger is a hint, a clue, a flag – just a small piece of information and only the beginning of the assessment process

12. Nutritional Status

- The Nutritional Status CAA process reflects the need for an in-depth analysis of residents with impaired nutrition and those who are at nutritional risk. This CAA triggers when a resident has or is at risk for a nutrition issue/condition. Some residents who are triggered for follow-up will already be significantly underweight and thus undernourished, while other residents will be at risk of under-nutrition. This CAA may also trigger based on loss of appetite with little or no accompanying weight loss and despite the absence of obvious, outward signs of impaired nutrition.

CAT Logic Tables



CMS's RAI Version 3.0 Manual CH 4: CAA Process and Care Planning

Nutritional Status CAT Logic Table

Triggering Conditions (any of the following):

1. Dehydration is selected as a problem health condition as indicated by:
   J1550C = 1
2. Body mass index (BMI) is too low or too high as indicated by:
   BMI < 18.5000 OR BMI > 24.9000
3. Any weight loss as indicated by a value of 1 or 2 as follows:
   K0300 = 1 OR K0300 = 2
4. Any planned or unplanned weight gain as indicated by a value of 1 or 2 as follows:
   K0310 = 1 OR K0310 = 2
5. Parenteral/IV feeding while NOT a resident or while a resident is used as nutritional approach as indicated by:
   K0510A1 = 1 OR K0510A2 = 1
6. Mechanically altered diet while NOT a resident or while a resident is used as nutritional approach as indicated by:
   K0510C1 = 1 OR K0510C2 = 1
7. Therapeutic diet while NOT a resident or while a resident is used as nutritional approach as indicated by:
   K0510D1 = 1 OR K0510D2 = 1
8. Resident has one or more unhealed pressure ulcer(s) at Stage 2 or higher, or one or more likely pressure ulcers that are unstageable at this time as indicated by:
   ((M0300B1 > 0 AND M0300B1 <= 9) OR
   (M0300C1 > 0 AND M0300C1 <= 9) OR
   (M0300D1 > 0 AND M0300D1 <= 9) OR
   (M0300E1 > 0 AND M0300E1 <= 9) OR
   (M0300F1 > 0 AND M0300F1 <= 9) OR
   (M0300G1 > 0 AND M0300G1 <= 9))

MDS 3.0 trigger logic is complex – CAT logic tables located within each CAA description (RAI Manual pages 4-16 to 4-41)

Care Areas

- Triggered care areas form a clinical link between MDS and care planning decision

- CAAs cover the majority of problem areas known to be problematic for NH residents
  - Other areas may need assessment as well
- Triggered CAA must be assessed → may or may not warrant being addressed by care plan

20 CAAs in the MDS 3.0

1. Delirium
2. Cognitive Loss/Dementia
3. Visual Function
4. Communication
5. ADL Function/Rehabilitation Potential
6. Urinary Incontinence and Indwelling Catheter
7. Psychological Well-being
8. Mood State
9. Behavioral Symptoms
10. Activities

20 CAAs in the MDS 3.0

11. Falls
12. Nutritional Status
13. Feeding Tube
14. Dehydration
15. Dental Care
16. Pressure Ulcers
17. Psychotropic Drugs
18. Physical Restraints
19. Pain
20. Return to Community

CAA Process

- Evaluate triggered areas, but CAAs do not provide exact detail on how to select pertinent interventions for care planning
  - Interventions must be individualized and based on effective problem solving and decision making approaches to all of the information available for each resident
- Care Area Triggers (CATs) identify conditions that require evaluation because of possible impact on specific issues and/or conditions, or the risk of issues and/or conditions

CAA Process

- Triggered items may or may not represent a condition that should or will be addressed in the care plan
- Significance and causes of any given trigger may vary for different residents or in different situations for the same resident
- Different CATs may have common causes, or various items associated with several CATs may be connected

CAA Process

- Indicate care area needs to be assessed more completely prior to making care planning decisions
- Triggered care area assessment may identify causes, risk factors, and complications associated with the care area condition
- Plan of care addresses these factors with the goal of promoting the resident's highest practicable level of functioning: (1) improvement where possible or (2) maintenance and prevention of avoidable declines
- A risk factor increases the chances of having a negative outcome or complication

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Care Area Assessment

- No specific tool mandated for completing the further assessment of the triggered areas
- No specific guidance on how to understand or interpret the triggered areas
- Instead, facilities are instructed to identify and use tools that are current and grounded in current clinical standards of practice, such as evidence-based or expert-endorsed research, clinical practice guidelines, and resources. When applying these evidence-based resources to practice, the use of sound clinical problem solving and decision making ("critical thinking") skills is imperative

Conducting the Assessment

Step 1: Identify the trigger

- Usually a sign, symptom, or other indicator of possible problem, need, or strength

Example:

Weight loss - loss of 5% or more in the last month or loss of 10% or more in last 6 months

Conducting the Assessment

Step 2 : Identify the triggered Care Area

Example:

1 or 2 – YES, on physician-prescribed weight-loss regimen or YES, not on physician-prescribed weight-loss regimen (K0300 = 1 or 2) triggers *Nutritional Status* care area

Conducting the Assessment

Step 3 : Conduct thorough assessment of the entire Care Area

- Include factors that could cause or contribute to the symptom
- Include factors for which the symptom places the resident at risk
- *Some factors will be on the MDS, many will not*

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Conducting the Assessment
Tools Requirement

- Must be current, evidence-based or expert-endorsed research and clinical practice guidelines/resources
- The facility should be able to identify the resources they use upon request
- Requirement is consistent with F492 – services must meet professional standard of quality

Appendix C Resources

- Staff should follow their facility's chosen protocol or policy for performing the CAA
- Resources provided in Appendix C are not mandated
- CMS does not endorse the use of any particular resource(s) including those in Appendix C
- Resources selected may be used outside of RAI process also

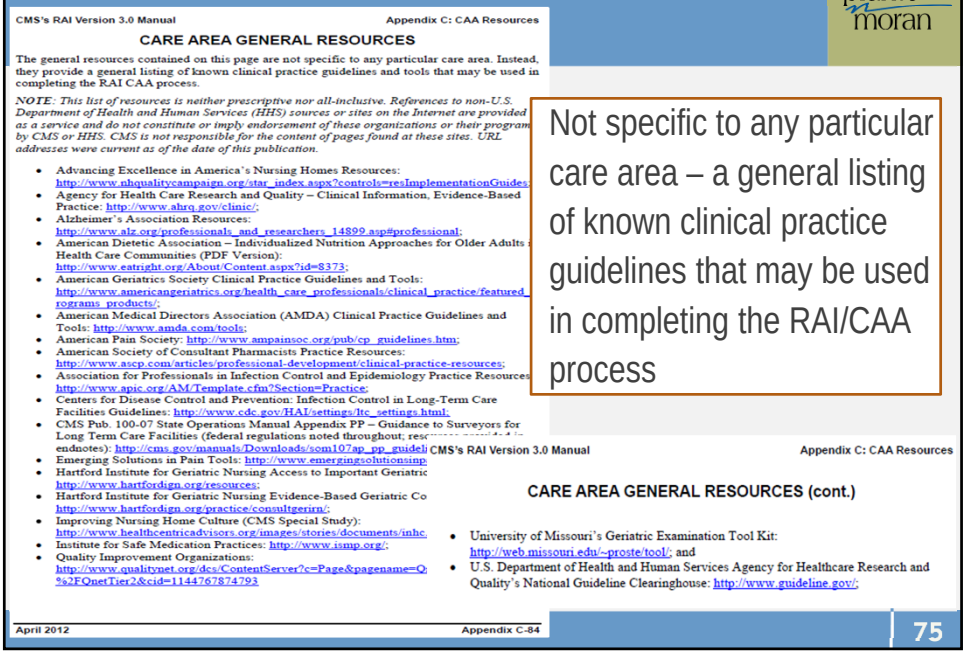
Conducting the Assessment
Tools Option 1

- *Review of Indicators* for each care area provided in Appendix C
- Each provides a checklist of indicators that guides the assessment for the particular care area
- Also provides location and guidelines for documentation

Conducting the Assessment
Tools Option 2

- Appendix C also offers a list of resources that may be used for this purpose
  - May be accessed online or through professional associations or other organizations
  - Not an exhaustive list – providers are free to use others that meet regulatory requirement

Other Care Area General Resources



CMS's RAI Version 3.0 Manual — Appendix C: CAA Resources

CARE AREA GENERAL RESOURCES

The general resources contained on this page are not specific to any particular care area. Instead, they provide a general listing of known clinical practice guidelines and tools that may be used in completing the RAI CAA process.

NOTE: This list of resources is neither prescriptive nor all-inclusive. References to non-U.S. Department of Health and Human Services (HHS) sources or sites on the Internet are provided as a service and do not constitute or imply endorsement of these organizations or their program by CMS or HHS. CMS is not responsible for the content of pages found at these sites. URL addresses were current as of the date of this publication.

- Advancing Excellence in America's Nursing Homes Resources: http://www.nhqualitycampaign.org/star_index.aspx?controls=resImplementationGuides;
- Agency for Health Care Research and Quality – Clinical Information, Evidence-Based Practice: http://www.ahrq.gov/clinic/;
- Alzheimer's Association Resources: http://www.alz.org/professionals_and_researchers_14899.asp#professional;
- American Dietetic Association – Individualized Nutrition Approaches for Older Adults i Health Care Communities (PDF Version): http://www.eatright.org/About/Content.aspx?id=8373;
- American Geriatrics Society Clinical Practice Guidelines and Tools: http://www.americangeriatrics.org/health_care_professionals/clinical_practice/featured_ rograms_products/;
- American Medical Directors Association (AMDA) Clinical Practice Guidelines and Tools: http://www.amda.com/tools;
- American Pain Society: http://www.ampainsoc.org/pub/cp_guidelines.htm;
- American Society of Consultant Pharmacists Practice Resources: http://www.ascp.com/articles/professional-development/clinical-practice-resources;
- Association for Professionals in Infection Control and Epidemiology Practice Resources http://www.apic.org/AM/Template.cfm?Section=Practice;
- Centers for Disease Control and Prevention: Infection Control in Long-Term Care Facilities Guidelines: http://www.cdc.gov/HAI/settings/ltc_settings.html;
- CMS Pub. 100-07 State Operations Manual Appendix PP – Guidance to Surveyors for Long Term Care Facilities (federal regulations noted throughout; res endnotes): http://cms.gov/manuals/Downloads/som107ap_pp_guideli
- Emerging Solutions in Pain Tools: http://www.emergingsolutionsinp
- Hartford Institute for Geriatric Nursing Access to Important Geriatric http://www.hartfordign.org/resources;
- Hartford Institute for Geriatric Nursing Evidence-Based Geriatric Co http://www.hartfordign.org/practice/consultgeirn/;
- Improving Nursing Home Culture (CMS Special Study): http://www.healthcentricadvisors.org/images/stories/documents/inhc.
- Institute for Safe Medication Practices: http://www.ismp.org/;
- Quality Improvement Organizations: http://www.qualitynet.org/dcs/ContentServer?c=Page&pagename=Q %2FQnetTier2&cid=1144767874793

CMS's RAI Version 3.0 Manual — Appendix C: CAA Resources

CARE AREA GENERAL RESOURCES (cont.)

- University of Missouri's Geriatric Examination Tool Kit: http://web.missouri.edu/~proste/tool/; and
- U.S. Department of Health and Human Services Agency for Healthcare Research and Quality's National Guideline Clearinghouse: http://www.guideline.gov/;

April 2012 — Appendix C-84

Not specific to any particular care area – a general listing of known clinical practice guidelines that may be used in completing the RAI/CAA process

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Conducting the Assessment

Step 4 : Draw conclusions based on the information collected

- What is causing or contributing to the problem for this resident?
- What is this resident at risk for related to the problem?
- What other health professionals should be involved?

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CAA Documentation

- Nature of the issue or condition - what is the problem for this resident?
- Causes and contributing factors
- Complications affecting or caused by the care area for this resident
- Risk factors that arise because of the presence of the condition
- Factors that must be considered in developing individualized care plan interventions
- Need for referrals to other health professionals

CAA Documentation

- Written documentation of the CAA findings and decision-making process may appear anywhere in resident's record
- No particular location or format is required
- Section V indicates Location and Date of CAA documentation related to decision-making

CAA Documentation

- Helps explain basis for care plan by showing how the IDT determined that the underlying causes, contributing factors, and risk factors were related to the care area condition for a specific resident
- Indicate basis for decisions – why the findings require an intervention, and the rationale for selecting specific interventions

CAA Documentation Popular Format

- Checklist with summary analysis

12. NUTRITIONAL STATUS

Review of Indicators of Nutritional Status

✓	Current eating pattern – resident leaves significant proportion of meals, snacks, and supplements daily for even a few days	Supporting Documentation (Basis/reason for checking the item, including the location, date, and source (if applicable) of that information)
☐	• Food offered or available is not consistent with the resident's food choices/needs — Food preferences not consistently honored — Resident has allergies or food intolerance (for example, needs lactose-free) — Food not congruent with religious or cultural needs — Resident complains about food quality (for example, not like what spouse used to prepare, food lacks flavor) — Resident doesn't eat processed foods — Food doesn't meet other special diet requirements	
☐	• Pattern re: food left uneaten (for example, usually leaves the meat or vegetables)	
☐	• Intervals between meals may be too long or too short	
☐	• Unwilling to accept food supplements or to eat more than three meals per day	

Care Area Review of Indicators

1. For any triggered care area(s), conduct a thorough assessment using care area-specific resources
2. Check the box in the left column if the item is present for resident. *Some of this information will be on the MDS - some will not*
3. In the right column next to each checked item provide supporting documentation regarding the basis or reason for checking the item, including the location and date of that information, symptoms, possible causal and contributing factor(s) for that item

Care Area Review of Indicators

4. Obtain and consider input from resident and/or family/resident's representative regarding the care area
5. Analyze findings in the context of their relationship to the care area. Include a review of indicators and supporting documentation, including symptoms and causal and contributing factors, related to the care area. Draw conclusions about the causal/contributing factors and effect(s) on the resident's functional ability and document this information in Analysis of Findings section

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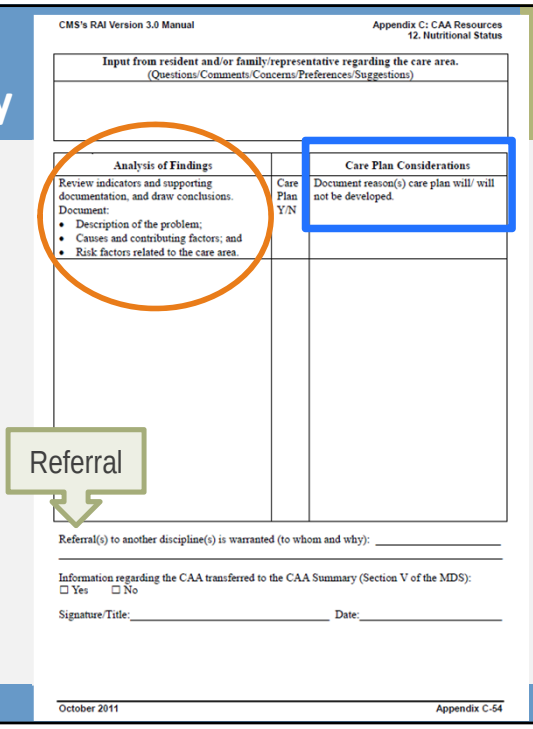
Care Area Review of Indicators

6. Decide whether referral to other health professionals is warranted and document decision
7. In Care Plan Considerations section, document if care plan will be developed and reason(s) why or why not
8. Transfer information regarding the CAA to the CAA Summary (Section V of the MDS)

CAA Summary


CMS's RAI Version 3.0 Manual
Appendix C: CAA Resources
12. Nutritional Status
Input from resident and/or family/representative regarding the care area.
(Questions/Comments/Concerns/Preferences/Suggestions)
Analysis of Findings
Review indicators and supporting documentation, and draw conclusions.
Document:
Description of the problem;
Causes and contributing factors; and
Risk factors related to the care area.
Care Plan Y/N
Care Plan Considerations
Document reason(s) care plan will/ will not be developed.
Referral
Referral(s) to another discipline(s) is warranted (to whom and why):
Information regarding the CAA transferred to the CAA Summary (Section V of the MDS):
☐ Yes ☐ No
Signature/Title:
Date:
October 2011
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CAA Process

- Documentation – focus on key issues:
  - Why or why not will you address the specific conditions in the care plan
  - What about the condition may affect the resident's daily functioning
  - Why did you decide the resident is at risk, that improvement is possible or the decline can be minimized
  - How could the resident benefit from consultation with an expert in a particular area

Remember

- Regardless of tool or format, documentation should walk through the evidence of and conclusions about the root causes, contributing factors, risk factors, referrals to other health professionals

V0200 CAAs and Care Planning

- Documents:
  - Which care areas triggered and require further assessment
  - Whether or not a care area is addressed in the resident care plan
  - Location and date of CAA information
- Reflects the IDT and resident's decisions on which triggered conditions will be addressed in the care plan

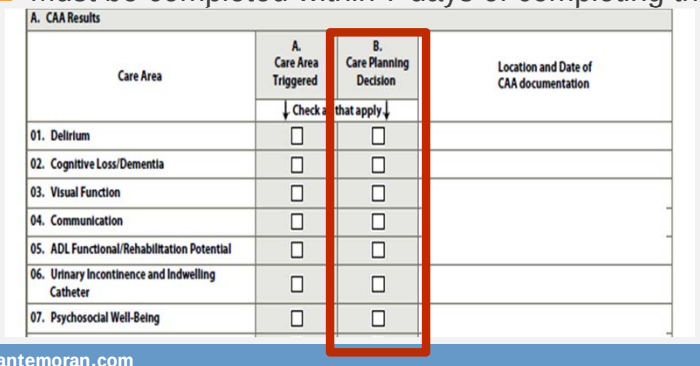
V0200A Column A - Care Area Triggered

- Facility uses the RAI triggering mechanism to determine which problem care areas require review and additional assessment
- Triggered care areas are checked in Column A

Care Area	A. Care Area Triggered ↓ Check all
01. Delirium	☐
02. Cognitive Loss/Dementia	☐
03. Visual Function	☐
04. Communication	☐
05. ADL Functional/Rehabilitation Potential	☐
06. Urinary Incontinence and Indwelling Catheter	☐

V0200A Column B – Care Plan Coding

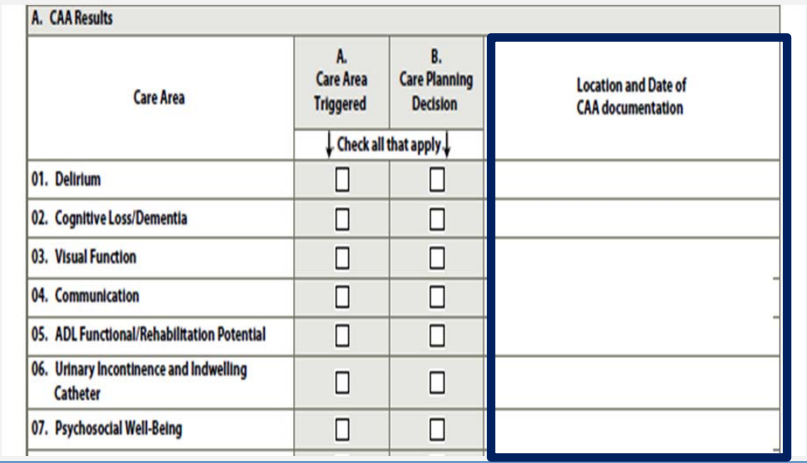
- Check Column B to indicate a decision to develop a new care plan, revise a care plan or continue a current care plan to address the problem(s) identified
- Must be completed within 7 days of completing the RAI



A. CAA Results			
Care Area	A. Care Area Triggered	B. Care Planning Decision	Location and Date of CAA documentation
	↓ Check all that apply ↓		
01. Delirium	☐	☐	
02. Cognitive Loss/Dementia	☐	☐	
03. Visual Function	☐	☐	
04. Communication	☐	☐	
05. ADL Functional/Rehabilitation Potential	☐	☐	
06. Urinary Incontinence and Indwelling Catheter	☐	☐	
07. Psychosocial Well-Being	☐	☐	

V0200 Location and Date of CAA Information

- Indicates date and location of the CAA documentation



A. CAA Results			
Care Area	A. Care Area Triggered	B. Care Planning Decision	Location and Date of CAA documentation
	↓ Check all that apply ↓		
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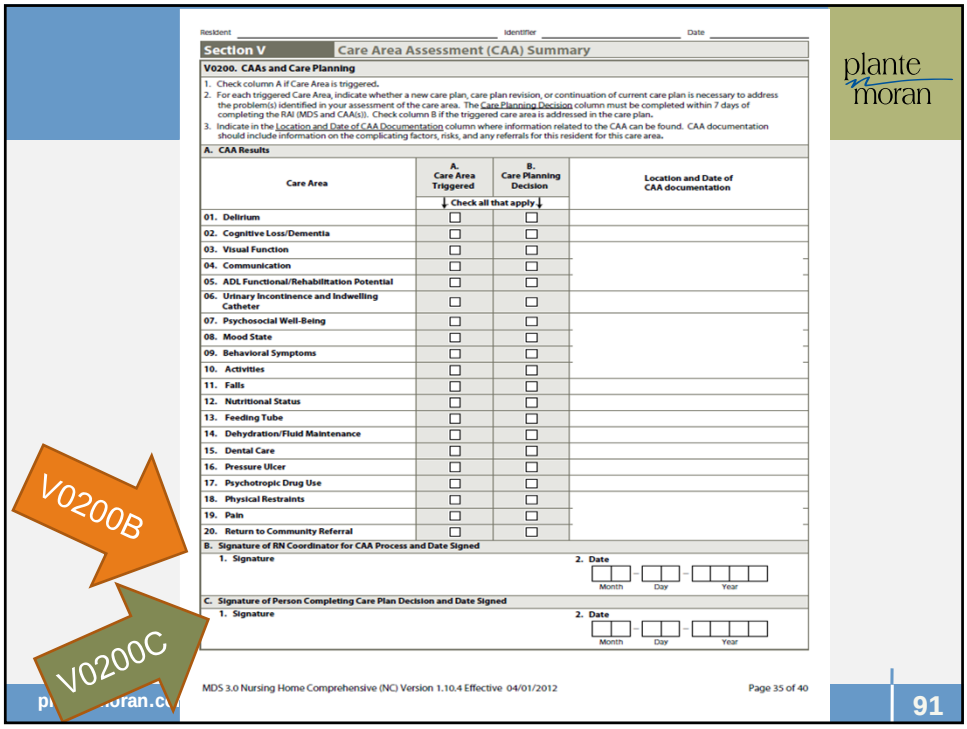
02. Cognitive Loss/Dementia	☐	☐	
03. Visual Function	☐	☐	
04. Communication	☐	☐	
05. ADL Functional/Rehabilitation Potential	☐	☐	
06. Urinary Incontinence and Indwelling Catheter	☐	☐	
07. Psychosocial Well-Being	☐	☐	


Resident
Identifier
Date
Section V
Care Area Assessment (CAA) Summary
V0200. CAAs and Care Planning
1. Check column A if Care Area is triggered.
2. For each triggered Care Area, indicate whether a new care plan, care plan revision, or continuation of current care plan is necessary to address the problem(s) identified in your assessment of the care area. The Care Planning Decision column must be completed within 7 days of completing the RAI (MDS and CAA(s)). Check column B if the triggered care area is addressed in the care plan.
3. Indicate in the Location and Date of CAA Documentation column where information related to the CAA can be found. CAA documentation should include information on the complicating factors, risks, and any referrals for this resident for this care area.
A. CAA Results
Care Area
A. Care Area Triggered
B. Care Planning Decision
Location and Date of CAA documentation
↓ Check all that apply ↓
01. Delirium
02. Cognitive Loss/Dementia
03. Visual Function
04. Communication
05. ADL Functional/Rehabilitation Potential
06. Urinary Incontinence and Indwelling Catheter
07. Psychosocial Well-Being
08. Mood State
09. Behavioral Symptoms
10. Activities
11. Falls
12. Nutritional Status
13. Feeding Tube
14. Dehydration/Fluid Maintenance
15. Dental Care
16. Pressure Ulcer
17. Psychotropic Drug Use
18. Physical Restraints
19. Pain
20. Return to Community Referral
B. Signature of RN Coordinator for CAA Process and Date Signed
1. Signature
2. Date
Month
Day
Year
C. Signature of Person Completing Care Plan Decision and Date Signed
1. Signature
2. Date
Month
Day
Year
V0200B
V0200C
MDS 3.0 Nursing Home Comprehensive (NC) Version 1.10.4 Effective 04/01/2012
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OBRA MDS 3.0 Timing

- V0200B1 = Signature of RN coordinating the CAA process
- V0200B2 = Date that RN certifies that CAAs have been completed. The CAAs must be reviewed and completed no later than the 14th day of admission (admission date + 13 calendar days) and ARD + 14 days for an annual, significant change in status, or a significant correction to a prior full assessment
- V0200B2 (CAA Completion) is the date of completion for comprehensive assessments and cannot be earlier than Z0500A

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OBRA MDS 3.0 Timing

- V0200C1 = signature of person facilitating care planning decision-making. Person signing does not have to be an RN
- V0200C2 = date on which staff person completed care plan decision column
- Care plan must be completed within 7 days of the completion date (V0200B2) of assessment (MDS and CAAs). V0200B2 + 7 days = V0200C2
- Date at V0200C2 times transmission for comprehensive assessments – must be sent within 14 days of V0200C2 (V0200C2 + 14 days)

Care Planning

- Good assessment forms the solid basis
- CAAs are the link between the MDS and care plan
- Plan of care is driven by resident problems, strengths, needs, preferences and choices
- Care plan by IDT
- Answer the "so what now" question
- *No required format or structure*

Care Planning

- Must have measurable goals and time tables
  - Goals should have a subject, verb, modifier and time frame
  - Mr. B will eat 75% of 2 meals daily within the next 3 months
- Approaches should identify what staff are to do and when they are to do it
  - Dietary to discuss with Mr. B food favorites and dislikes
  - Dietary to explore with nursing need for restorative eating program
  - Nursing to provide hands-on assistance when shows signs of fatigue or frustration

Care Planning

What the care plan needs to do:

- Indicates interventions in place to prevent avoidable declines in functioning or functional levels
- Manage risk factors
- Address resident strengths
- Use current standards of practice in the care planning process
- Evaluate treatment objectives and outcomes of care

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Care Planning

- Respect the resident's right to refuse treatment
- Allows resident to establish own goals
- Offer alternative treatment
- Use an interdisciplinary approach to care plan development to improve the resident's functional abilities
- Involve the family and/or other resident representatives, if OK with the resident

Care Planning

- Assess and plan for care sufficient to meet the care needs of new admissions
- Involve the direct care staff with the care planning process relating to the resident's expected outcomes
- Address additional care planning areas that could be considered in the long-term care setting

Questions??

Submit questions by dialing
#6 to unmute the phone line

After asking question, hit
*6 to mute the phone line again

Reminders

Ideas for the next series?

- Evaluation Forms
- Sign-in Sheet
- Audio Order Form

Preferably TODAY, but no later than 1 week from today

Next – July 19 from 1:00 to 2:30 PM EST

The Federal Focus on Unnecessary Medications

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- Thank you.

Jane Belt
Plante Moran Clinical Group
jane.belt@plantemoran.com
614-222-9020

Resources

- RAI MDS Manual http://www.cms.gov/Medicare/Quality-Initiatives-Patient-Assessment-Instruments/NursingHomeQualityInits/MDS30RAIManual.html
- MDS Training Materials https://www.cms.gov/NursingHomeQualityInits/45_NHQIMDS30TrainingMaterials.asp#TopOfPage
- SNF PPS Website https://www.cms.gov/SNFPPS/03_RUGIVEdu12.asp#TopOfPage